

DEPARTMENT OF THE ARMY
US ARMY MEDICAL DEPARTMENT ACTIVITY
Fort Huachuca, Arizona 85613-7040

MEDDAC Memo
No. 600-3

30 June 2004

Personnel General
CLINICAL STAFF HEALTH PROGRAM

	Para	Page
HISTORY -----	1	1
PURPOSE -----	2	1
DEFINITIONS-----	3	1
SCOPE -----	4	1
REFERENCES -----	5	1
RESPONSIBILITIES -----	6	1
PROCEDURES-----	7	3
APPENDIX A - References -----		A-1
APPENDIX B - Staff Education -----		B-1
APPENDIX C - Blood Alcohol Determination -----		C-1

1. HISTORY: This issue publishes a revision of this publication.
2. PURPOSE: The organization has a responsibility to treat and rehabilitate in a non-punitive fashion medically-impaired clinical staff. This memorandum provides key information that MEDDAC leaders and staff use to identify, treat, rehabilitate, and monitor clinical staff suspected of being impaired from a health problem.
3. DEFINITIONS: An impaired provider (IP) refers to any clinical staff member, active duty or civilian, licensed or non-licensed, paid staff or volunteer, who has a medical, psychiatric, or substance abuse disorder that adversely affects his or her ability to provide safe and competent patient care.
4. SCOPE: This memorandum applies to all licensed independent practitioners (LIP), licensed personnel, and clinical support staff--as well as their supervisors, leaders, peers, and treating providers.
5. REFERENCES: See Appendix A.
6. RESPONSIBILITIES:
 - 6.1 The Provider Health Committee (PHC) will:
 - 6.1.1 Advise the MEDDAC Commander as needed regarding the management and oversight of IPs.
 - 6.1.2 Serve as an advocate both for the provider and for the patients under his/her care.

*This memorandum supersedes MEDDAC Memo 600-3, 21 February 2001

6.1.3 Promote fair and equitable treatment of all IPs.

6.1.4 Design a staff development plan to educate all MEDDAC staff on their responsibilities in identifying possible impairment, while incorporating elements of impairment prevention, education about provider impairment, and well-being issues.

6.1.5 Ensure appropriate and timely coordination between the Provider Health Committee and the Credentials Committee.

6.1.6 Coordinate reporting of impaired providers (IP) via through appropriate clinical and administrative channels.

6.1.7 Review the evaluations from the Army Substance Abuse Program (ASAP) and/or treating physician of any provider staff member referred to the PHP for evidence of impairment.

6.1.8 Recommend facility-specific procedures for the management of IPs.

6.1.9 Recommend appropriate restrictions on the clinical practice for impaired providers who are LIPs and forward recommendations to the Credentials Committee.

6.1.10 Recommend appropriate restrictions on the clinical practice for all non-LIP clinical support staff and forward them to Quality Management, the MEDDAC Company Commander, and/or MEDDAC Commander as appropriate.

6.1.11 Monitor the progress of the impaired individuals during treatment, through aftercare, until the completion of the ongoing monitoring phase.

6.1.12 Recommend an individualized plan for the gradual return to full clinical practice for each IP staff member who has completed treatment.

6.1.13 Ensure the Department/Service Chief is informed and will serve as a resource to the Department/Service Chief regarding recommendations concerning monitoring or employee confrontation.

6.1.14 Ensure the Company Commander, Civilian Personnel Office, or Contracting Representative is notified for civilian personnel as appropriate.

6.1.15 Request/coordinate monitoring if there is no clear evidence of impairment.

6.1.16 Obtain a statement of diagnosis, prognosis, and implications on clinical performance from the treating or rehabilitating care provider.

6.2. The Deputy Commander for Clinical Services (DCCS) will:

6.2.1 Serve as the Chair of the Provider Health Committee.

6.2.2 Confront the IP with evidence of impairment and notify them of their enrollment in the PHP.

6.2.3 Meet with each IP before and after their treatment program intervention to clarify implications for future practice and the risks of treatment relapse.

6.2.4 Ensure that members receive appropriate training to assume the responsibilities of the committee.

6.3 The MEDDAC Company Commander will:

6.3.1 Initiate personnel flagging, UCMJ action, or any investigations of possible criminal conduct involving IPs as appropriate.

6.3.2 Pursuant to the recommendations of the PHC, execute referrals of IPs to the Army Substance Abuse Program (ASAP).

6.3.3 Special considerations with regard to the management of active duty personnel who are intoxicated while on duty are covered in Appendix B.

6.3.4 Staff enrolled as IPs in the PHP will cooperate with the PHP Program in accordance with AR 40-68. The MEDDAC Commander will institute enrollment of an active duty IP into a treatment program if that provider refuses to enter treatment. If the impaired HCP is a civilian employee, the civilian program coordinator of the ASAP and appropriate CPAC representatives will be notified prior to the intervention. Consequences for refusal to enter treatment will be given in advance.

6.4 MEDDAC staff will: Report to their first-line supervisor's clinical staff known or suspected of being impaired IAW AR 40-68.

6.5 Supervisors will refer to the PHP clinical staff under their supervision suspected of being impaired to the DCCS for further guidance.

6.6 The Clinical Director, ASAP will:

6.6.1 Serve as the clinical case manager for all IPs with impairment from alcohol or substance abuse.

6.6.2 Give progress reports to the PHC on IPs under their care IAW AR 600-85, Army Substance Abuse Program (ASAP).

6.6.3 Report to the chairman of the PHP any provider who self reports as having potential impairment.

7. PROCEDURES:

7.1 Case identification:

7.1.2 Identification by self: The primary responsibility for the identification of the impaired employee lies with the individual concerned. Self-reporting to a first-line supervisor or other appropriate authority is encouraged.

7.1.3 Identification by peers: Since denial is often a feature of many significant health problems, peers must be aware of the potential signs and symptoms of health impairment and notify their first-line supervisor when they identify a potential PHP issue (see Appendix B).

7.1.4 Identification by supervisors or other organizational leaders: Supervisors and leaders may elect to confront potential IPs-- or may delegate this responsibility to the PHC and DCCS. In the former case, supervisors will provide the PHC a copy of a formal written counseling describing the symptoms observed or other evidence of impairment, along with the intent to refer the staff to the PHP. In the latter case, supervisors will provide to the PHC a memorandum for record describing the evidence that a given clinical staff may be impaired. Supervisors should seek or obtain legal counsel prior to confronting a potential IP.

7.2 Notification of the IP: The DCCS will meet with each IP to notify them that they are being followed by the PHP committee, to explain the purpose of the committee, and to answer questions. This notification will be documented in writing and will be kept on file with other Impaired Provider documents in the Quality Management Office, RWBAHC.

7.3 Removal of the IP from patient care: The decision to remove a provider from direct patient contact requires the consent of the PHP. Pursuant to the recommendations of the PHC, the DCCS, with the consent of the MEDDAC Commander, will execute any actions involving the removal of a provider from patient care.

7.4 Treatment and rehabilitation: The PHC will refer IPs to the appropriate treating service and clinical case managers. The DCCS will execute the referral and serve as the liaison between the PHC and the treating service.

7.5 Aftercare/Follow-up Care: Aftercare is the treatment program for alcohol and substance abuse involving the remainder of the 1-year enrollment, following the initial intervention and residential inpatient treatment as needed. The purpose of aftercare is to promote long-term recovery. Tours of active duty for impaired HCPs will be stabilized at least 12 months from the date of admission to the treatment program IAW AR 614-5. Exceptions are in cases where the community does not possess sufficient aftercare resources or where there are insufficient HCPs in the same work role as the recovering provider. Major leadership positions and solo practices are to be avoided. In these cases, an exception to policy will be initiated so the HCP can be reassigned to an appropriate duty station.

7.5.1 Return to clinical practice: After one year of treatment, rehabilitation, and monitoring, the PHC will determine whether the IP is a treatment success. The PHC may recommend a full or conditional return to clinical care or practice. The MEDDAC Commander is the approval authority for return to clinical care. HCPs who have abused controlled drugs are generally restricted from prescribing or administering controlled drugs after return from treatment. HCPs working in anesthesiology should not generally return to this specialty when their impairment has been addiction to drugs. If, in the opinion of the PHC a return to the previous specialty is not appropriate, a recommendation for change of AOC will be initiated. Approval rests with the appropriate corps chief.

7.6 Ongoing monitoring. Ongoing monitoring refers to the observations, reports, and meetings required over a 2-year period to assess the progress of the HCP who has returned to duty. The ASAP is involved in monitoring during the first year of aftercare. The supervisor, department chief, and PHC will continue monitoring for a second year. The committee will review the progress of each impaired IP monthly for the first 3 months of treatment and at least quarterly thereafter until 2 years from the date of return to duty.

7.7 Relapse: Any Individual treating or monitoring IPs will notify the PHP upon any sign of relapse or failure to follow the treatment and/or aftercare plan. The PHP will, in addition to repeating the steps required to identify, notify, and treat as described above - make additional recommendations appropriate to the Credentials Committee (for LIPs) or DCCS (non-LIPS)

7.8 Program Termination: The role of the PHP generally ends after the second year following successful treatment or rehabilitation. At this time the PHC will recommend termination of monitoring unless review findings or relapse require further involvement. AR 600–85 requires that all military personnel, E5 and above, who are identified as drug abusers be processed for separation from the Army per AR 635–100 and AR 635–200. The unit commander initiates the separation process. Each level of command to the general courts-martial convening authority (GCMCA) recommends approval or disapproval of the separation. The GCMCA is the first level at which the separation process can be stopped and the HCP retained on active duty. However, the GCMCA may request determination by a DA board.

7.9 Reports, Records, and Minutes:

7.9.1 The *clinical case manager* will submit verbal or written reports to the PHC at periodic PHC meetings on a monthly basis for three months and then quarterly for a minimum of one year after entry into the treatment program or while in aftercare. These reports describe the results of drug and alcohol screens if appropriate, compliance with the treatment program, and progress with treatment and rehabilitation goals.

7.9.2 The *supervisor* of the department where the IP works will submit monthly verbal or written reports to the PHC monthly for the first three months and quarterly thereafter

for two years after entry into the PHP. These reports should focus on behavior and other applicable aspects of job performance.

7.9.3 The PHC will submit progress reports to the Credentials Committee as needed on any impaired provider who is a LIP. For LIPs or certified clinical staff (not LIP) whose practices are restricted, QM will submit DD Form 2499 for submission to higher command IAW AR 40-68 on any licensed or certified clinical staff (not LIP). For active duty non-privileged clinical staff, the DCCS or DCHS as the agent of the PHC, will prepare quarterly MORs or counselings as needed. Note: non-privileged nurses for example, also get reported on DD Form 2499. anybody with a license or certificate will be reported on 2499.

7.9.4 All PHC records will be maintained in the Credentials Office. The confidentiality requirements of AR 600-85 and AR 40-68, apply to all reports, committee minutes, and discussions pertaining to IPs. (See para 1-7 and AR 40-66.) The documents of the Provider Health Program are considered Quality Assurance documents and as such are protected under Title 10 USC, Section 1102 (b). Unauthorized disclosure is prohibited.

7.9.5 Notification to professional regulating authorities: Notification will be made per paragraph 4-9k for HCPs who are privileged. For nonprivileged HCPs, reports will be sent through the next higher headquarters to HQDA (SGPS-FP), 5109 Leesburg Pike, Falls Church, VA 22041-3258. Regional Medical Commands will notify their drug and alcohol clinical offices of all cases of impairment. Notification will be made for any HCP who: (1) Has clinical privileges suspended, limited, restricted, or revoked; revoked; (2) Possesses, prescribes, sells, administers, gives, or uses any drug legally classified as a controlled substance for other than medically acceptable therapeutic purposes; (3) Separates from active duty or Federal Service in a less than full (defined) clinical practice; (4) Leaves at any time for any reason during the 2-year monitoring period.

The proponent of this publication is Deputy Commander for Clinical Services. Users are invited to send comments and suggested improvements to the Deputy Commander for Clinical Services, ATTN: MCXJ-DCCS, USA MEDDAC, Fort Huachuca, AZ 85613-7040

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APPENDIX A REFERENCES

1. References consulted in detail for this policy update:

AR 40-68, Quality Assurance Administration, 20 Dec 89

AR 600-85, Army Substance Abuse Program (ASAP), 1 Oct 01

RWBAHC Memorandum 15-1, Committees & Minutes

RWBAHC Rules and Regulations of the Medical Staff, current edition.

2. References not specifically cited for this policy update but which may be consulted for more information as needed:

AR 614-5, Stabilization of Tours, 1 Apr 84.

MEDCOM Regulation 40-38, Command-Directed Mental Health Evaluations, 1 Jun 99.

Department of Defense Directive (DoDD) 6490.1, Mental Health Evaluations of Members of the Armed Forces, 1 Oct 97.

Department of Defense Instruction (DoDI) 6490.4, Requirements for Mental Health Evaluations of Members of the Armed Forces, 28 Aug 97

Negotiated Agreement between USA MEDDAC and American Federation of Government Employees Local 1662.

Title 10 United States Code Section 1102, Confidentiality of Medical Quality Assurance Records: Qualified Immunity for Participants

Public Law 91-513, The Comprehensive Drug Abuse Prevention and Control Act of 1990.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO), current edition.

APPENDIX B STAFF EDUCATION

Staff training on the Provider Health Program

1. At initial and annual organizational training, all MEDDAC employees will be educated on the basic purpose of the PHP - and trained to identify the key indicators of impairment*, and action for employees to take when the indicators are identified.

Indicators of impairment include, but are not limited to, the following:

An odor of alcohol on the breath.

Emotional lability.

Sleepiness or dozing off while on duty.

Lack of coordination, unsteady gait, falling.

Change in job performance e.g., sloppy/illegible hand writing.

Lapses in memory or confusion; slurred speech.

Pin-point/dilated pupils associated with hypo/hyperactivity.

Excessive absenteeism, i.e. abuse of leave and a pattern of being absent on Mondays and Fridays.

APPENDIX C BLOOD ALCOHOL DETERMINATION

Special Considerations involving active duty personnel who are intoxicated while on duty

1. Intoxication on duty is defined as a Blood Alcohol Test (BAT) of .05 or greater
2. If a MEDDAC soldier is observed or suspected to be intoxicated while on duty, the soldier's supervisor will notify the DCCS or DCHS immediately, who will make arrangements for the soldier to receive an immediate medical evaluation. The MEDDAC company commander will also be contacted to initiate necessary administrative actions.
3. The Medical Company Commander or, in his/her absence the MEDDAC Commander, will initiate MEDDAC Form 185, Sobriety Exam and Blood Alcohol Determination.
4. The Commander may also request a command directed urinalysis. This is accomplished by the Unit Drug and Alcohol Coordinator.
5. The Commander will notify the MPs of drug/alcohol abuse suspected to have occurred on the Health Center grounds.
6. A qualified provider will perform an appropriate medical evaluation and fitness for duty determination. If the provider determines that the individual is fit for duty, he/she will be returned to duty. If the medical officer determines that the individual is impaired, he/she will be relieved from duty and dispositioned as appropriate.
7. If the soldier is released to quarters, a family member or the Charge of Quarters will be notified to provide transportation. Under no circumstances will an impaired soldier be permitted to drive home.